EXHIBIT BB

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

****

IN RE: ETHICON, INC. PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION

Master File No. 2:12-MD-02327

MDL No. 2327

****

JOSEPH R. GOODWIN
U.S. DISTRICT JUDGE

This Document Relates to Plaintiff:

Barbara Kaiser
Case No. 2:12-cv-00887

****

DEPOSITION OF MARIA A. ABADI, MD

Thursday, March 31st, 2016

10:27 a.m.

Held At:

Butler Snow

1700 Broadway

New York, New York

REPORTED BY:

Maureen O'Connor Pollard, RMR, CLR, CSR

APPEARANCES:

FOR THE PLAINTIFF:
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E X H I B I T S

P R O C E E D I N G S

MARIA A. ABADI, MD,
having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PLOUFF:

Q. Please state your name.

A. Maria A. Abadi.

Q. And you are Ethicon's expert pathologist in this case, is that right?

A. Yes, that is correct.

Q. What do you perceive your role to be as an expert witness?

A. Okay. My role is to assess the pathology of Ms. Kaiser, to examine -- in this particular case, I examined the tissues, I processed some of the tissues, and I performed a microscopic evaluation. I was also in charge of reviewing Dr. Iakovlev's report, and to give my opinions as to his report.

Q. And when you say that one of the things you are to do is to assess Mrs. Kaiser's tissue, that has to be done in a fair manner, is that right?

A. Yes, with the proper pathologic methodology.

Q. Right.

And in this case your job was to report what you saw in the Kaiser tissue, and that would be factual in nature, is that right?

A. That is correct.

Q. If there were changes due to mesh, you would report that, correct?

A. Yes. If I saw any changes that were related to the mesh, yes, I had -- absolutely had to report that.

Q. Okay. Obviously I have your written report on the Kaiser matter. It is a -- well, I notice the pages not numbered now that I have looked at it, but it is a six-page report dated March 16th, 2016. And you issued that report, correct?

A. Yes, I did.

Q. All right. And are all the opinions that you hold on the Kaiser matter disclosed in your written report?

A. Yes.

Q. So you do not hold any opinions that are not disclosed, is that correct, in your

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written report?
A. That is correct.
Q. Okay. Who contacted you regarding the Kaiser case?
A. Who contacted me?
Q. Yes.
A. It was Mr. Andrew Snowden from Butler Snow.
Q. And when was that?
A. It was about the same time as the other cases. I would say the end of 2015.
Q. Okay. When he contacted you initially about any cases, I mean, did he talk to you about any one particular case, or just in general whether you would be an expert witness for Ethicon?
A. Yes, it was in a general manner, not specifically to any case.
Q. Is that the first time that you had ever talked to Mr. Snowden?
A. No. I spoke to him in the summer of 2015 just in general, and he gave me a case initially that I -- eventually I did not perform the review. And then after that he contacted me for these cases. And it was always in a general

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manner.
Q. And before the summer of 2015, had you ever had any contact with Mr. Snowden?
A. No.
Q. So how many cases have you reviewed for Ethicon?
A. So far I have reviewed -- you mean written the reports, or just general review?
Q. Well, let's start with general review, and then let's go with written reports.
A. Okay. Initially I was sent more cases, I was sent about ten cases, and I started working on them, you know, doing the microscopic review, and eventually some of the cases did not go forward, and so I ended up writing reports for five cases.
Q. Okay. And do you know why the other five cases did not go forward?
A. No, I have no idea. I was just contacted to return those cases.
Q. Okay. Had you provided any opinions about those cases to anyone before you returned the case?
A. No, no. Because they did not go forward, they didn't want my report, so even

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though I had started writing some notes it didn't come to pass, so I did not discuss the findings with anybody.
Q. Okay. When did you look at Mrs. Kaiser's tissue for the first time?
A. So I don't have the chain of custody with me, but I was sent some of her tissues. I believe it was at the beginning of this year.
Q. Where -- do you have -- you don't have the chain of custody in your black binder?
A. No, it's not included in the black binder.
Q. Okay. I mean, how many chain of custody forms do you have?
A. Oh, I have many chain of custody forms.
Q. No, I'm talking about for Ms. Kaiser's case.
A. Well, yes, there were several, too, because some -- you know, they sent -- every time they send me a chain of custody form, it would have the copies of the other people that had the, you know, the tissues at one point or another.
Q. Okay. You don't have a way to produce

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those today?
A. No, I don't.
MR. PLOUFF: I'd ask counsel to produce those in the future. Is that all right?
MR. COMBS: Yes. Sure, yes, Tom, we'll be glad to produce them. I'm going to display my ignorance. I don't know whether you already have them or not, in terms of I don't know whether the Plaintiff's chain of custody forms are given to the defense and the defense chain of custody forms are given to the Plaintiff. I just don't know the answer to that. That's all handled by Butler Snow. But yes, we will get you the chain of custody forms related to the Kaiser case.
MR. PLOUFF: Okay. Fantastic.
BY MR. PLOUFF:
Q. When did you first look at Dr. Iakovlev's report?
MR. COMBS: And one last thing, Tom. If I could, could I just ask you please to send me a reminder e-mail so I can forward that to someone at Butler Snow?
MR. PLOUFF: Sure. What's your e-mail?

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(Off the record discussion.)
MR. COMBS: So we're back on the record.
BY MR. PLOUFF:
Q. And my next question is, when did you first look at Dr. Iakovlev's report on Mrs. Kaiser?
A. Okay. It was after I had already processed my part of her tissues and done my microscopic evaluation.
Q. The tissue that you looked at for Mrs. Kaiser, did it appear to be preserved properly?
A. Well, it was sent informally, but similar to Mrs. Wroble, I don't know what was the time -- the fixation time, in other words, when was the tissue placed in formalin in the first place.
Q. Would that affect the results at all?
A. Absolutely. You know, if you have the tissues just in a container without any fixative they will dry and they will shrink, so yes, it affects the preservation of the tissues.
Q. I mean, did you see any evidence of drying or shrinkage?

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A. Oh, yes, there is -- in all these cases, there is some degree of some shrinkage. In part it's due to -- perhaps in this case, which I don't know what was the -- what we call the ischemic time, meaning the time from when the tissue is excised to the time when it's put in formalin, it affects that. But also the formalin itself can cause shrinkage.
Q. So how would you go about determining whether -- well, let me ask you this.
Do you have an opinion in terms of what period of time -- well, no, let me rephrase that.
Typically for a mesh sample like this, will a hospital pathologist put it in formalin, or will it come to them in formalin from the operating room?
A. Right. In this particular case, if you see the pathology report dated November 13, 2013, you would see that the specimen came fresh, so it was not placed in formalin.
Q. Okay. And is there -- will a hospital pathologist after taking a look at the fresh sample typically put it in formalin?
A. Yeah, but I would expect some note in

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the report as to that, that it was placed in formalin for fixation, which it is not -- is not present in the report, so I really don't know if the pathologist at Northwestern put the tissue in formalin or if it was sent somewhere else and then upon arrival placed in formalin.
Q. And if you wanted to determine when it was placed in formalin, how would you go about figuring that out?
A. Oh, I don't know. It would have to be based on in your records. I don't know where the tissue was sent to, and I don't know if they, you know, have any notes as to when the tissue was placed in formalin.
Q. Okay. When you say it's "placed in formalin for fixation," what does that "for fixation" mean?
A. That means that you have what is pre-prepared containers with buffered formalin, that's formaldehyde 10 percent, and they come pre-prepared, so what the pathologists do in these cases is that they describe them, and then they place the tissue in these formalin containers. But in pathology we also have empty containers, so it's possible they put in an

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empty container as opposed to a form -- a prefilled formalin container.
Q. And what does the term -- what does the phrase "for fixation" mean?
A. Fixation means that you stop the ischemic time. "Ischemic time" means when you excise the tissue you cut off blood supply, and therefore, the tissue starts to degrade. So when you fix it means you basically fix that process, you -- to put a stop to it so the tissue doesn't continue to degrade. And you can look at it with -- in the microscope, and you will see that it is preserved.
Q. Do you have any opinion when it comes to Mrs. Kaiser's tissue, and let's assume that it wasn't in formalin when the hospital pathologist looked at it, how much time would have to elapse between that pathologist looking at it and it being placed in formalin for any of the shrinkage to be due to that period of time?
A. Well, I really don't know. I cannot based on her tissues assess the ischemic time, but I can tell you -- you know, exactly. But I can tell you that her tissues were preserved, in fact. You could evaluate them with no problem.

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So I don't assume that the ischemic time -- the ischemic time in this particular -- in Ms. Kaiser was very prolonged.

Q. And what do you mean by "not very prolonged"?

A. Well, when you see degeneration, you see a lot of autolysis in the tissues, you know, the inflammatory cells start to look very distorted, because the lymphocytes in particular are very fragile. So any autolysis that occurs, meaning degradation to the tissue due to lack of fixation, you would see that.

So if you have a pre-machine type specimen where the blood vessels are healthy where you can assess the quality of the connective tissue of the inflammatory cells, then that's a well-preserved specimen.

Q. So, I mean, when you use the term "not a very prolonged amount of time," you know, does that mean within hours, within days, within months?

A. Right.

Q. Can you be any more specific on that?

A. Sorry, yes. You know, basically if you let tissue stand for too long without any

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preservation, it will start to autolyze. There are certain tissues that degrade much rapidly. In other words, for example, liver or kidney or certain tissues, they degrade pretty fast. And there are others, like connective tissue, that degrade much slower. And, for example, if you have collagen, it may be preserved for longer. So that means days.

Q. Okay. And the -- you know, if you're speaking to another pathologist, some of these phrases might mean something like not very prolonged or too long or pretty fast, but to me I'm trying to get a better handle on the time frame here. I mean, do you have an opinion that this tissue was placed in formalin within 24 hours of the pathologist looking at it?

A. Yeah, based on the preservation, my estimate is that, yes, that it was probably placed before 24 hours.

Q. Can you say whether it was placed within four hours?

A. No, I cannot give you that time frame, because I really -- I really don't know, because the -- for the most part, this is fibroconnective tissues, and I said to you that

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you can have fibroconnective tissue not put in formalin for days and sometimes even months and nothing would happen.

And the reason why I'm saying to you that I think it's less than 24 hours is because I could see the inflammatory cells, I could see the vessels, so they were actually well preserved, so my opinion is that it had to be less than 24 hours. Now, to give you an exact time before that, I cannot.

Q. Do you think that if the tissue was placed in the formalin after 12 hours that you would be able to see the inflammatory cells in the vessels?

A. Yes, you could see inflammatory cells, but you can also see areas were -- are not so well preserved. So you would see, for example, some what we call crushing artifact, you know, where -- or streaming artifact. You will see some artifactual distortion.

Q. And did you see artifactual distortion here?

A. I may have. I don't have it in my notes, so it was probably something that I could dismiss. There are certain artifacts in

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pathology that pathologists are used to look at, and basically you just disregard them.

Q. So is it artifactual distortion can be seen in a situation where there's been some period of time that's gone by before the tissue is placed in the formalin?

A. Yes. You know, every time you don't fix a tissue right away, it might cause some form of distortion. I mean, distortion is caused by many factors, not just the fixation. It is also caused by the processing of the tissue itself.

Q. I mean, can you -- given the fact that you could see the inflammatory cells in the vessels, can you say that this tissue was placed in the formalin within 18 hours of the -- within 18 hours?

A. Yes. Likely, yes. It is well-preserved, so I would expect that the tissue was placed in formalin even at the time -- after the pathologists initially performed their evaluation at Northwestern.

Q. Oh, okay. So you're saying that from all -- you have no reason to suspect that the tissue was not placed in the formalin

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immediately after the pathologists looked at it, is that right?
A. Correct. Yes.
Q. Okay. And so the -- you know, given the fact that it appears that the tissue was immediately placed in the formalin, do you think that if there was any shrinkage of the mesh it could be due to the delay in placing the tissue in the formalin?
A. Well, as I --
MR. COMBS: Object to form.
A. Sorry. Should I...
MR. COMBS: Yes. No, you can answer.
A. Yes, there are certain things that can be due to the time, what I said, the ischemic time, or it could be the formalin itself, because formalin is known to shrink tissue as well.
BY MR. PLOUFF:
Q. Okay. And do you know, shrink tissue or shrink mesh?
A. No, shrink tissues.
Q. Okay. Did you see any shrinkage of the mesh in Ms. Kaiser's case?
A. Well, there's no shrinkage of mesh.

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The mesh is embedded in this fibrous tissue, and the fibrous tissue is the one that actually shrinks and contracts. The mesh in itself is just embedded into it. It's just a framework. What shrinks or, you know, or remodels is the collagen that it's ingrown into -- it's incorporated into that mesh.
Q. How long would the ischemic time have to be for the tissue to contract due to the amount of ischemic time?
A. As I said, it depends on the tissues. It depends on what kind of tissues --
Q. On Ms. Kaiser's --
A. Right. The problem with this case is that not only you have fibroconnective tissue, but you can also have surrounding adipose tissue, and that tends also to shrink.
Q. My question simply had to do with, you know, how much ischemic time would there have to be to cause any shrinkage of the tissue in Mrs. Kaiser's case?
A. I cannot give you an exact time. It could be days or it could be weeks, I don't know. As I said to you, collagen usually takes time to degrade, so...

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Q. And when you're referring to "ischemic time," does that time start when the tissue is explanted from the body?
A. Correct, because once you cut off the blood supply, once you cut in the, you know, the nourishment of the tissues, then the tissues start to degrade. That's known, because obviously you don't have the support system. It's just like when you have, you know, a skin wound, you see that, you know, once it detaches from the blood supply it's dead, dead skin. It's the same concept.
Q. Do you have an opinion as to whether, you know, any -- as to what extent Mrs. Kaiser's tissue shrink was due to ischemic time?
A. Well, first of all, I don't know if she had any ischemic time. We just talked about that. We don't know for how long the tissue was not placed in formalin, so I cannot have an opinion as to whether her ischemic time caused shrinkage because I really don't know what time she -- this tissue was placed in formalin.
The only thing I can tell you is that based on the preservation of the tissues, I assume that after the pathologists looked at

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this tissue, they placed it immediately in formalin. And I receive it in formalin, so there is no reason for me to believe that it wasn't done right away.
Q. And, you know, this is just due to my ignorance on the subject of ischemic time, but it appears to me that, you know, even if it was placed in the formalin immediately by a pathologist, there would still be some period of time that elapsed between when it was explanted from Mrs. Kaiser and when the pathologist looked at it, and wouldn't that qualify as ischemic time?
A. Yes, that's right. The problem is that sometimes, let's say you have an excision, right, an excision occurs in the operating room, then that tissue obviously has to be sent to pathology. The time of transportation is taken into account. Then we don't know -- let's say the surgery occurs late in the day, may not be delivered to the pathology laboratory until the following day, it may be placed in a refrigerator. You know, there are so many other variables that come into play with this, so it depends --

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Q. Is it evident --
A. I'm sorry.
-- it depends on what time -- we would have to look at the collection time in the medical system, and then the accession time or receiving time in the laboratory to really assess ischemic time.
Q. Okay. And do you have any opinion as to whether or not the period of time that elapsed between when the specimen was collected in Ms. Kaiser's case and when the pathologist looked at it, whether that ischemic time caused any shrinkage of tissue?
A. Based on the appearance of the tissues, I do not believe that the ischemic time was of relevance here, and --
Q. Okay. So you don't think that any of the shrinkage of the tissue was due to ischemic time in Ms. Kaiser's case, is that correct?
A. Correct. Right.
Q. And then turning to the formalin aspect of this, do you have any opinion whether the formalin caused a shrinkage of the tissue?
A. Yes, formalin always causes shrinkage of tissue. Always.

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Q. Can you quantify that in any way?
A. Yes, it's about -- the range is usually between 4 to 10 percent of the tissue volume.
Q. Okay. You reviewed the records of the explanting physician, Dr. Lisa Johnson, is that right?
A. Yes, I did.
Q. And what is your understanding as to why Dr. Johnson removed some of Mrs. Kaiser's Prolift mesh?
A. Okay. Well, what I saw in the records is that she was having several complaints. She was having complaints of pain during intercourse, she was having complaints of pain while she was sitting, standing, walking. She was having bladder spasms, groin pain. And then when they did -- when Dr. Johnson examined her, she found that she could palpate the vaginal mesh, and that there was any stricture, and she that had tenderness in the area. So I guess with the vaginal stricture and her pains, they just -- and the palpation of the mesh that they decided to explant the mesh.
Q. Are you -- just in general, a

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pathologist like yourself, are you ever asked by a treating doctor if there's anything in the tissue that you examine that could cause pain?
A. Yes, we have -- we have been -- yes, pathologists like myself have -- request sometimes of what could possibly cause the pain in a patient, yes.
Q. Give me some examples of that, if you would.
A. For example, if you have -- if the clinician suspects any form of inflammation in the colon, for example colitis, then you have -- you know, if they think that that's the source of the pain, then, you know, you're asked to give an opinion as to whether there is inflammation, how severe it is, and if it really affects, you know, the main aspects of the tissue, like, for example, glands.
So you -- there are many ways to go around pain. It depends on the pain, and it depends on the findings on the histology. And many times, and oftentimes, you know, the clinician thinks there is pain -- not thinks there is pain, no, that the patient reports pain, the physician feels that there's pain in a

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certain area, but the histology doesn't show the changes.
Q. And in that situation do you accept that the patient can still have pain regardless of the histology not supporting it?
A. That is correct, yes. That -- the fact that you don't see it in histology doesn't rule the symptom -- doesn't rule out that the patient has pain.
Q. And other than -- I found your colon example very interesting. Any other examples where, in other organs, where you're sometimes asked by a treating doctor whether the tissue would be corroborative of pain?
A. Yes. For example, in many other organs, like, for example, bone, you know, if the, you know, patient experiences, let's say, pain at night, then the doctor, you know, believes the pain is caused, for example, by a tumor, then you obviously look for the cause of that pain. And if you find tumor, that's the likely cause of the pain in that patient.
Q. So the colon, the bone, other examples --
A. Oh, no, there are many examples. You

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know, every -- you know, different organs and different tissues can give you information as to whether there is pain or not, except that there are some times when, you know, the patient experiences pain, but you cannot definitely correlate it or you cannot correlate it at all.

Q. Okay. So just in terms of like, I was going to ask you the top five in terms of situations as a pathologist where you've been asked by a treating doctor whether what you were looking at in a tissue sample could cause pain, I assume a couple in the five would be the colon and the bone. Is there anything that you could add to that that would round out the top five?

A. Well --

MR. COMBS: And --

A. I'm sorry.

MR. COMBS: And objection to the form. But also, Tom, I mean, obviously this is totally a general deposition, and Dr. Abadi got deposed on general cause issues and her general report on Tuesday, so this is supposed to be a deposition focusing on Ms. Kaiser.

MR. PLOUFF: Right. And because Ms. Kaiser has complaints of pain, I think it's

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an appropriate area of inquiry.

BY MR. PLOUFF:

Q. So go ahead, Doctor.

A. Well, I wouldn't -- it's not based on organs, it's based on etiology. In other words, you know, when the doctors, you know, request or they are concerned about pain in a patient, they are not -- it's not about the organ in itself, it's about what could cause that pain, what -- if you can find a cause to that pain. And sometimes, as I said, you cannot.

And so what you would look for is -- as I mentioned in my general deposition, you would look for causes of pain like ulceration, like infection, like acute inflammation, like necrosis, or more often than not in our practice, neoplasms.

Q. Right. And I understand that from your general deposition, but I'm asking you if you can simply give me the top five situations that you've experienced with treating physicians where you were asked whether the tissue would support a claim of pain.

MR. COMBS: Object to form.

A. Well, you can have -- as I said to

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you, you can have colon, you can have bone, you can have bladder. If you have urothelium in the bladder, you can have it in soft tissues. I mean, there are many organs where you can find a source of pain.

BY MR. PLOUFF:

Q. So there are many different organs where physicians had asked you whether the tissue sample from that organ could be corroborative of a complaint of pain, is that right?

A. Yes, that is correct.

Q. Have there been any situations you've been in, not as an expert witness, but as a treating pathologist, where you've been asked by a treating physician whether any tissue you looked at from the vagina could be a cause of complaint of vaginal pain?

MR. COMBS: Object to form.

A. No. Normally for the vagina, the requests are a little different.

BY MR. PLOUFF:

Q. Okay.

A. So, in other words, you know, mostly when a doctor conducts a biopsy of the vagina,

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it's usually to look for other things.

Q. Okay. You know that, in terms of the mesh that was implanted in Mrs. Kaiser, that it was Prolift mesh, is that right?

A. Yes, that is correct, that's what I have in my records.

Q. Were all five of your reports on Prolift mesh?

A. No. I had Gynecare mesh, Gynemesh, Prolene Soft.

Q. How many were for mesh for pelvic organ prolapse repair?

A. I think there were five.

Q. Okay. And do you know whether in all five cases that the -- that an indication for the removal of mesh was pain?

MR. COMBS: Object to form.

A. If in all five it was for pain? Is that --

BY MR. PLOUFF:

Q. Yes.

MR. COMBS: Yes. And also just object again. I mean, this is not a question about Ms. Kaiser's case.

MR. PLOUFF: Well, it relates to her

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credibility on Mrs. Kaiser's case.
BY MR. PLOUFF:
Q. Go ahead, Doctor.
A. Okay. So the patients in all five -- in all of those five cases, they have different complaints, among them was pain, but the pain was in different ways. I mean, pain either by dyspareunia or spasm or, you know, different types of pain.
Q. Okay. But a common thread that ran through the five mesh cases you reported on is that there was a complaint of pain in some respect that gave rise to the explant of the mesh, is that correct?
MR. COMBS: Object to form.
A. Yes, in the cases that I reviewed, yes, the complaint of pain was one of the factors that were taken into account for the removal of the mesh.
BY MR. PLOUFF:
Q. Okay. How many hours have you put into Mrs. Kaiser's case?
A. Ms. Kaiser was about, I would say, 30 hours.
Q. Did you -- have you -- have you billed

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for that time yet?
A. Well, I have a basically general bill that included, you know, all five cases and also my general report. It's not itemized.
Q. Was that bill marked as an exhibit during your general deposition the other day?
A. No. I brought it, but it wasn't marked.
Q. Okay. Do you have it with you today?
A. No, I did not because I didn't -- I wasn't asked during my general deposition. I didn't bring it today.
Q. Sure. Do you have -- have you put any time -- since you issued that bill, have you put in any additional time into your Ethicon work?
A. Yes, but I haven't submitted any additional time. But I have, yes.
Q. And do you have an estimate of the additional time range?
A. Yes, I gave it on Tuesday. My original --
Q. Don't worry about it then. Don't worry about it.
A. Okay. All right.
Q. Yes. And what did you say your --

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well, did you say your billing rate was $500 an hour?
A. Yes. That is correct, yes.
Q. And is that the same for whether you're reviewing the records or giving deposition or trial testimony?
A. Yes.
Q. Okay. Now, I want to go through Dr. Iakovlev's report with you, and I think the --
MR. PLOUFF: If I could have the reporter mark that as Exhibit 1.
(Whereupon, Abadi Exhibit Number 1, Dr. Iakovlev's Report titled Clinico-Pathological Correlation of Complications Experienced by Ms. Barbara Kaiser, was marked for identification.)
MR. PLOUFF: It's a 29-page report.
A. I think it's already been marked.
BY MR. PLOUFF:
Q. Okay. So turning to Page 10 of that report, do you see where there's a Figure BK1?
A. Yes, I see that.
Q. Now, do you have a picture of the

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gross specimen before division that's comparable to this, or not?
A. No, I don't.
Q. Okay. And you accept the fact that what's depicted here in Figure 1 is the picture of the gross specimen of the mesh and tissue that was explanted by Dr. Johnson for Mrs. Kaiser, is that right?
A. Yes, I assume that this was before the division took place. Right?
Q. Okay. Yes.
A. Yes.
Q. All right. And you accept that all of the figures of mesh and tissue that are depicted in Pages 11 to 29 of Dr. Iakovlev's report are from -- pertain to Mrs. Kaiser, is that correct?
A. Let me see.
(Witness reviewing document.)
A. Yeah, I assume that he took all these pictures from Ms. Kaiser's tissues.
BY MR. PLOUFF:
Q. Okay. And you -- were you present when the tissue was divided?
A. No, I wasn't.
Q. And do you know when that happened?

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A. No, I have no idea.
Q. Okay. When -- I think I asked this of you earlier, but I forget the answer. When did you say you -- did you have a date when you first looked at Mrs. Kaiser's tissue?
A. Yes, I mentioned to you that that date is in the chain of custody, and that I don't recall it.
Q. Oh, okay. And do you know -- and when did you first draft your report on this case?
A. So after I received the tissues, then I processed them, then I evaluated them, and that's when I started writing my draft, you know, based on my observations of the tissues and the, you know, the microscopy.
Q. And the next thing you did apparently was you saw Dr. Iakovlev's report and you were responding to some of the things that he opined on, is that right?
A. Yes, correct. After constructing my report based on the medical records, and my own observations of the tissue, then it's -- when I received his report, and then I started my opinions of his report.
Q. Okay. And when did you complete that

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process?
A. As I said, for Ms. Wroble, it was that weekend that everything was completed. That was before the March 16th deadline.
Q. Okay. So let's see here. Let me go back and look at my calendar. March 16th was on a Wednesday, so you're saying your report on the Kaiser case was finalized on that -- the Saturday or Sunday before the March 16th?
A. Yes, pretty much. It was just -- it was already written, it was just a matter of, you know, correcting some things here and there.
Q. Okay.
A. Editing basically.
Q. How much sooner had it been already written?
A. It was -- I would have to look at the dates when I received all the materials, but basically it was already -- it had been already written a week or so before.
Q. Okay. And there were certain slides that were created by Dr. Iakovlev, is that right?
A. There were certain slides that were created by Dr. Iakovlev, yes.

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Q. And then you -- at some point you looked at those, is that right?
A. Yes. Let me just check in my report, because I think that was -- yeah, I think that was part of the delay, because initially I just had my slides, and then I received his slides later on.
Q. And have you returned those slides?
A. Yes, everything has been returned. Even my slides -- even my slides were sent to, I believe, Dr. Iakovlev at this point.
Q. Okay. And have you provided to Dr. Iakovlev the specimens and slides that you were working with?
A. Yes, I provided him with everything, except that obviously the gross tissue is no longer available because he's made into slides. But all the slides were provided to him, yes, all the stains.
Q. Okay. Now, in terms of the five -- Well, actually, let me ask it this way, because you talked earlier about how you had reviewed 10 mesh explantations for Ethicon and reported on five, correct?
A. Correct, I started the review -- I did

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not complete the review on the others, because --
Q. Okay. I'll just refer to them as the first five. But did those first five involve mesh explanted for pelvic organ prolapse?
A. Oh, I don't recall. I don't recall what the specifics were for those cases.
Q. Okay. Do you know if there were any evidence of erosion of the vagina for those first five?
A. No, I did not have enough time to assess all that. I basically got -- some of the slides, some of the sets were incomplete, and some medical records. That was it. It was too premature.
Q. And the five that you --
A. Yeah, sorry.
Q. No, I'm -- it's hard when it's over the phone to know when you've stopped with your answer, so I'm trying to wait, but if I don't just tell me you have more to say.
The five that you reported on, how many of those did you see evidence of erosion?
MR. COMBS: Yeah, and again, objection. This is totally going to the general

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deposition. This is why we had a deposition on Tuesday. You know, Tom, I've given you just scads of leeway on this, but, you know, this isn't about Ms. Kaiser's case.

MR. PLOUFF: Well, I think it relates to her credibility on Mrs. Kaiser's case.

MR. COMBS: This is not what the purpose of this deposition is. The purpose of this deposition is for you to ask questions about Ms. Kaiser's case. If you wanted to ask questions about the general -- about other cases, what she did with the other 10, those are the questions that were to be asked on Tuesday. That's not what this is about.

MR. PLOUFF: Well, I, you know, I suppose in the eyes of the beholder in terms of what is a case-specific question. But I think that if it relates to her opinions on Mrs. Kaiser's case, it relates to her credibility on Mrs. Kaiser's case, that they are appropriate.

MR. COMBS: That's not what this deposition is about. Let's call Judge Eifert and just get this resolved, because we're not going to have a deposition of two hours of

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questions about other cases that aren't Ms. Kaiser's case, so let's --

MR. PLOUFF: Okay. Go ahead and get Judge Eifert on the phone then.

MR. COMBS: Yeah, I'm going to. I'm going to try to get her phone number.

We can go off the record now.

(Off the record discussion.)

(Whereupon, phone call to Judge Eifert was made from 11:12 a.m. to 11:30 a.m.)

BY MR. PLOUFF:

Q. Okay. Doctor, on the five cases that you reported on for Ethicon, did you see erosion in any of the tissue?

A. Yes, I did.

Q. In how many of the five?

A. I believe it was one. It may have been two, but I -- as far as I remember right now, one.

Q. And in the one or two where you saw --

MR. COMBS: And objection. Tom, excuse me. I'm trying to interpose an objection.

Objection to the use of these other

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cases in this case in this case-specific deposition. Thank you, Tom.

MR. PLOUFF: Sure. And I can give you a continuing objection on that also.

BY MR. PLOUFF:

Q. In those one or two cases where you saw erosion, did you attribute any of the erosions to the transvaginal mesh?

A. The mesh was in the vicinity, but the erosions that I identified were not related to the mesh specifically.

Q. Okay. Now, the -- and obviously in Dr. Iakovlev's report, you know, he has these figures, you know, 2 to 20 is it, and I think that your report has four figures attached to it. Would it be fair to say that the tissues that you looked at had the same features as the tissues that Dr. Iakovlev looked at?

A. Yes, that is correct.

Q. Okay. Now I want to start walking through some of these Iakovlev figures.

A. Yes.

Q. And Figure 2, for example -- or yeah, I'm just going to -- I'm going to knock out the BK, I'm just going to refer to them as Figure 2

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at Page 11. The middle picture there, you see some yellow areas designated, is that right?

A. Yes. Yes, I do.

Q. Do those represent the spaces in the mesh, between the mesh fibers?

A. Well, as a pathologist I would prefer to rely on -- upon the first figure, because the rest is just his drawings, so I would not consider that any scientific measure of how the pores look. So I would rather base my assessment on the first figure, because the rest is just -- he's drawing over what's supposed to be the pores.

Q. Okay. Well, what he says is represented by the yellow in the middle picture are spaces between the mesh fibers, and if you want to look at the top picture you can do that, but I'm going to relate the yellow in the middle to the white in the top and say, you know, do you agree that the areas that he says in yellow are spaces in the mesh are, in fact, spaces in the -- between the mesh fibers?

A. Yes, it appears to be so.

Q. Okay. Do you -- in the bottom figure he is putting yellow what he believes the likely

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plane of the mesh was. Do you have a -- do you agree with what he opines is the likely plane of the mesh?
A. Absolutely not.
Q. Okay. Do you have an --
A. That is only belief. That's only make believe that -- that's completely arbitrary from his part.
Q. Do you have an opinion on what the most likely plane of the mesh was in the top picture in Figure 2?
A. Well, first of all, you cannot -- with these tissue fragments and with what was received from Ms. Kaiser, you cannot give an opinion as to the orientation of this tissue in vivo.
First of all, if you go back to Figure Number 1 just for -- you know, to walk from that figure to Number 2, there are three pieces. The surgeon that excised the mesh, in this case Dr. Johnson, I believe, did not say how these three pieces were positioned in the body. There is no indication what is interior, what is posterior, what is caudal, what is cephalad, so you have no orientation whatsoever of these

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tissues, you don't know how they are placed. And you don't know how they are actually related to each other.
So for that, to be -- to take that and just write lines, you know, and with a software to make believe that those are the planes is absolutely wrong. It's not even pathology methodology.
MR. PLOUFF: Move to strike as non-responsive.
BY MR. PLOUFF:
Q. Doctor, my question to you is simply, do you have an opinion on what the likely plane of the mesh was on the top figure in figure -- the top picture in Figure 2?
A. And I'm saying that no, there is no way to determine the orientation of the fibers or the mesh in vivo, therefore, there is -- based on these pictures, I can't give you the orientation of this mesh in vivo.
Q. Okay. The -- you note in your report on the second unnumbered page regarding the Dr. Johnson surgery that there was a palpable tense band anteriorly from one ischial spine to the other. Do you have an opinion as to whether

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the three mesh and tissue samples you see in Figure 1 on Page 10 of the Iakovlev report came from that palpable tense band?
A. Well, you know, according to her report she said that she excised some of the mesh, but I don't know what is left or what is right.
Q. Do you know it all came from the palpable tense band that she refers to?
A. I have no -- I don't know how much of that tense band meant the mesh, or what was other tissues incorporated into that. I have no idea, because when she submitted these tissues, the only thing she said was vaginal mesh. She did not explain where exactly in the vagina or where in that tense band she took this tissue from.
Q. Okay. The -- going back to Dr. Iakovlev's report at Page 11, Figure 2, the very top picture there, do you -- does that show folded mesh?
A. Again, you know, these tissues, after they have been excised, they go through a lot of manipulation. They are go -- they go through manipulation during excision because the surgeon

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is trying to pull the tissue out of the patient, and then they get manipulation when they go into pathology, and they are measured and they are cut. So this is after division, after that has been cut in the laboratory, it has been processed, and then cut again with a microtome. And so what you're seeing here is not a reflection of how that mesh looked in the patient. This is after too many factors, too many variables that have been introduced. So that would not be a reflection of how this mesh looked in the patient.
Q. Okay.
MR. PLOUFF: And I move to strike as unresponsive.
BY MR. PLOUFF:
Q. Doctor, I'm not asking you if this represents how the mesh looked in the patient. My question simply is, does the top picture in Figure 2 show folded mesh?
A. No, you cannot assess folding with a bidimensional picture.
Q. Does the top figure -- the top picture in Figure 2 show a dense collagenous scar?
A. It just shows fibrosis. There's no

way to assess density with a picture.
Q. Where -- in the middle picture of Figure 2 where he's labeled certain areas as scar, and you can look at the comparable areas in the top picture if you prefer, but are those areas, in your view, properly described as scar tissue?
A. Whether you call it scar or fibroconnective tissue or fibrosis is all the same, it's type I collagen.
Q. So regardless of whether you call it fibrosis or scar, you see he's properly identified those areas, is that correct?
MR. COMBS: Object to form.
A. Well, I would not identify them as a scar, just fibrosis. But if he wants to use that term, it's fine.
BY MR. PLOUFF:
Q. Okay. So if I crossed out the word -- in the middle picture if I crossed out the word "scar" and I inserted the word "fibrosis," you would agree that those areas show fibrosis, is that right?
A. Yes.
Q. Okay. Was there any normal non-scar

tissue with -- well, you're saying you don't see any mesh folds in the top picture of Figure 2, correct?
MR. COMBS: Object to form.
A. I just see the pores. I don't see any folds. There's no way to assess folding with just a -- folding is something that occurs just as a trimensional concept. You cannot do that with a photograph that is only showing you two dimensions.
BY MR. PLOUFF:
Q. Do you -- is there no normal non-scar tissue within the pore areas?
A. Well, this is a very low magnification. I don't know if there are vessels in-between the pores, I cannot see at this magnification, it's a very low magnification.
Q. Well, regardless of magnification, based upon the Figure 2 pictures, can you see any normal non-scar tissue within the pore area?
A. No, the picture only depicts the fibrosis and the mesh.
Q. Okay. Do -- let's -- I think it's already been marked perhaps as Exhibit 2, I

think it's the four figures attached to your report. Can you put that in front of you, Doctor?
(Whereupon, Abadi Exhibit Number 2, Four color figures, was marked for identification.)
A. Sure. Absolutely.
BY MR. PLOUFF:
Q. Thank you.
A. I'm ready.
Q. Now, do any of your -- I see. So, for example, in your first figure there you're describing an area of fibrosis, is that right?
A. Correct.
Q. All right. And how do you -- how do you -- how do you identify the fibrosis area? I mean, is it everything that's pink in this picture?
A. Yeah, when you see an H&E slide, the fibrosis looks pink, it looks homogeneously pink.
Q. Okay. Do any of your four figures show any mesh fibers within a fibrosis area of tissue?
MR. COMBS: Tom, could you repeat that

question? I could not hear you.
MR. PLOUFF: Sure.
BY MR. PLOUFF:
Q. I'm on your four figures right now. My question is, do any of them show mesh fibers within the area of fibrosis?
A. Yes, actually Figure 1, if you see I put "Fibrosis" as a text box. Do you see that in the first figure?
Q. Well, I'm reading the -- I'm reading what you have there in the first figure, and it's probably just due to my ignorance, Doctor, but I'm trying to figure out if there are mesh fibers shown within that figure or not. Are there?
A. Yes. Actually, if you see the legend, it says "Mesh associated with mild chronic inflammation and fibrosis."
Q. Oh, I see, the blue area -- now I'm with you.
A. Okay.
Q. So the mesh is indicated by the purple in this slide?
A. Well, the mesh is actually, if you see the empty spaces, you know, that's part of the

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mesh.
Q. Yes.
A. And if you see the top of the figure, there is a folded blue thing. Do you see that?
Q. Yes.
A. Well, that's actually a polypropylene fiber. That is -- because the fibers on histology look blue, so when they have been removed, what you'd get is empty spaces.
Q. Okay. But what -- you have the arrow pointing to a purple area, is that correct?
A. Right. That area is inflammation.
Q. Oh, I see.
Can you see any mesh -- other than the mesh that's the blue line at the very top, can you see any mesh anywhere else in Figure 1?
A. Oh, yes, all those empty spaces that you see, if you were to polarize that, you would see mesh fibers.
Q. So all the white areas?
A. Correct.
So what Dr. Iakovlev does for you is that he colors those spaces.
Q. Okay. So on your Figure 1 where you have the arrow and then there's the purple area

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for inflammation next to that, and then to the right of that is this big white area, that big white area would all be mesh, is that right?
A. Correct.
Q. Okay. On your Exhibit 2, Doctor, could you simply write the word "mesh" into that white area, please?
A. Into the white -- into the -- in my Figure 2?
Q. In your Figure 1 I thought we were on.
A. Oh, sorry. Okay.
Q. The white area that's next to the blue arrow, the one to the right there, I believe you've designated that as mesh, if you could just write the word "mesh" in that.
A. Yes.
Q. Are you done?
A. Almost (witness complies).
Q. Okay.
MR. COMBS: Do you want a thinner pen?
A. No, it's just with my handwriting it may not look so clear.
Yes, I did that.
BY MR. PLOUFF:
Q. Let's go to the next page of

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Dr. Iakovlev's report, Page 12, Figure 3.
A. Yes.
Q. Do you see any dense collagenous scar in the top picture?
A. I just see fibrosis, the same in all the three pictures.
Q. Okay. Does the phrase "dense collagenous scar" mean anything to you?
A. Yes, sometimes it's used in pathology when you see it more homogeneous than in some other cases, just to separate it from when you say "loose connective tissue." So when you see -- when you use the term "dense scar" or "dense fibrosis," it just means that it's more compact.
Q. Okay. Do you see any areas of fibrosis in Figure 3 that are more compact?
A. Which -- Figure 3 of Dr. Iakovlev, you mean?
Q. Yes, yes.
A. Yes, the fibrosis is pretty homogeneous in this picture.
Q. When you say the fibrosis is homogeneous, is that the same thing as saying that the fibrosis is dense?

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A. Well, it just means that when you stain it, it's pretty much regular staining throughout.
Q. Okay.
A. In other words, if you see any area of this picture, you would see that the quality of the staining is the same.
Q. And can you determine the density of the fibrosis?
A. Yes, you can see whether -- you know, if you see a slide that contains different areas of the tissue, you can see areas where the fibrosis is a little bit more compact and dense than others.
Q. Okay. The -- if you'd look at -- I'm sorry to flip back and forth with you, but on your four figures, Exhibit 2, can you use any of those pictures to show me where an area would be -- of the fibrosis is denser than other areas?
A. Yes, absolutely. If you go to Figure 2.
MR. COMBS: So, Tom, it's Exhibit 2, Figure 2.
MR. PLOUFF: Right.
A. Okay. So do you see that in some

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areas around the fibers it's a little pinker than in other areas? Like, for example, on the bottom of the page of the picture, you would see it's a little bit more loose, you know, there's like some separation of the tissues, and actually in the middle of the picture as well there's lighter pink. I don't know if you can see it.
BY MR. PLOUFF:
Q. Okay. Well, could you just -- as an example, if you could just take your pen and draw a line to where an example of dense fibrosis, and then go ahead at the end of the line write the word "dense," please.
A. Okay. So I think I need a better pen. Yes, that's fine. This is fine.
MR. COMBS: Okay.
A. I'm just going to put, in the area that's dense put "dense," and then in the area that is less dense I would put "less dense." How is that?
BY MR. PLOUFF:
Q. Oh, that's great.
A. (Witness labeling).
MR. COMBS: Okay. And, Dr. Abadi,

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just -- Tom, I think it might be helpful if Dr. Abadi circled that with a Sharpie just because it's going to be pretty hard in a copy of this picture to see this.
MR. PLOUFF: Okay.
MR. COMBS: Just make a big -- make a, you know, a circle around the two areas just so that the --
THE WITNESS: (Witness complies). Like that? Okay.
MR. COMBS: That's perfect.
THE WITNESS: Okay.
MR. COMBS: Thank you.
A. These are just examples. Doesn't mean that the whole picture does not represent the same things.
BY MR. PLOUFF:
Q. I understand.
And again, using your Exhibit 2, the four figures there, do you see any areas that you would say show lymphocytic chronic inflammation?
A. Yes. In fact, in Figure 2 I mark it with a black arrow. Do you see that?
Q. I do.

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A. So that is my lymphocytic chronic inflammation.
Q. You know, but I'm not -- to me the purple area -- or excuse me. The black arrows indicating the lymphocytic inflammation, it seems like the arrow is pointing to purple dots, is that right?
A. Yes, that's how the lymphocytes look in the tissue, like purple dots, exactly right.
Q. Okay. So wherever -- even like at the bottom of this Figure 2, there are also purple dots. Are those similarly areas of lymphocytic inflammation?
A. Yes, that is correct, those are lymphocytes.
Q. Okay. And what is a lymphocyte?
A. A lymphocyte is a chronic inflammatory cell.
Q. Okay.
A. So the one that we have in the lymph nodes.
Q. Okay. Now, let me flip you back to Exhibit 1, Dr. Iakovlev's report, again Page 12, Figure 3.
A. Yes.

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Q. Do you -- do any -- and I guess you like to use the top picture, which is fine, but does that top picture in your view show any areas of lymphocytic inflammation?
A. Yes, it does.
Q. Okay. And would those be the areas in purple?
A. Yes, that's correct. The areas in purple.
Q. And then if you could just draw a line from one of those purple areas as an example and write "lymphocytic inflammation," please?
A. (Witness complies).
Q. And then when you're done, just let me know.
A. Okay. I'm done.
Q. Okay. And then do I assume that the reason why the lymphocytes in your Figure 2 show up as purple dots and the ones in Dr. Iakovlev's Figure 3 appear more blurred is just due to the amount of magnification?
A. That is correct.
Q. All right.
A. He used for his picture a 1.6 objective, and mine are basically 20x.

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Q. Now, the areas of -- I guess we can use your Exhibit 2 where you designate on Figure 1 as the pink areas of fibrosis, do you have an opinion as to whether that fibrosis was caused by the Prolift mesh?
A. Well, the fibrosis is actually an intended result, because there is no other way to heal but with scar tissue when you have a foreign body material like a mesh. So it's been designed to actually facilitate the deposition of collagen. So that's the result that is expected, and then that's the result that it shows here.
Q. Okay. And I'm not necessarily asking what the intended result of the mesh is. I just want to make sure that a -- that the fibrosis is in your opinion caused by the transvaginal mesh, correct?
A. Yes, it's caused by the mesh, right.
Q. Okay. All right.
A. Once you place the mesh, the result is the fibrosis.
Q. Turning to Dr. Iakovlev's report again, Exhibit 1, Figure 4, the top picture there, do you see any folded mesh in that

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picture?
A. Figure -- I'm sorry, which figure?
Q. Figure 4 at Page 13 of Dr. Iakovlev's report.
A. Page 13. Okay. Again, you cannot assess folding with a picture that is flat, that it has two dimensions.
Q. Okay. Do you know what the basis for Dr. Iakovlev describing Figure 4 as folded mesh is?
A. I have no idea what went through his head, because there's no way to do that with this kind of a specimen.
Q. Okay. The Page 14 of Exhibit 1, Dr. Iakovlev's report, Figure 5, you see areas of chronic inflammation, is that correct?
A. Yes, I do.
Q. And would you agree that it's not normal to have that amount of inflammation in this tissue?
MR. COMBS: Object to form.
A. Well, first of all, the figure, as you said -- you remember that we spoke about the little dots, right? So --
BY MR. PLOUFF:

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Q. Right.
A. -- you see the impression that he gets from this picture is there's a lot of inflammation because there's a lot of smudging of the cells here. You know, you see how it looks like little dots in some areas and then bands that are purple? Well, that's an artifact, that is the -- it's a crushing artifact, and that happens because the lymphocytes are very fragile. So it gives you the impression that it's a lot more inflammation than what's really there.
And in terms of whether chronic inflammation is normal or abnormal, chronic inflammation in the presence of a foreign body material is normal, that's what you expect to see. It doesn't go away.
Q. Well, let's use a figure from your report then, Figure 2 of Exhibit 2, that shows the lymphocytic inflammation with purple dots.
A. Okay.
Q. In a woman who does not have a mesh implant, would you expect to see this type of inflammation?
A. Yes.

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Q. From what?
A. Well, the vaginal mucosa shows inflammation, always has inflammatory cells, always has chronic inflammatory cells. And so as I explained before, we have what we call the surveillance cells, so the presence of chronic inflammatory cells in the vaginal mucosa is entirely normal.
Q. Well, here's what I don't get on this subject then.
A. Yes. Right.
Q. On the one hand you say it seems to me to be saying that the inflammation that's seen is caused by the mesh, and that it's an intended result of the mesh, and on the other hand you say that even in the woman without mesh you can see this type of inflammation. So how can you say it's related to the mesh?
MR. COMBS: Object to form.
A. Right. So this is the situation. In a normal vagina you get inflammatory cells, you get a chronic inflammation infiltrate always, and that's normal. The only reason why we're saying that this is in relation to the mesh is because you see it around the fibers. But every

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time you have a foreign body material you would have the same type of inflammation. Any foreign body material, whether it's a suture, whether it's a prosthesis, whether it's a mesh, it would have the same chronic inflammatory response.

When I talk about normal, it's because that's what -- how the organism, I mean the host, reacts to a foreign body no matter what the foreign body is.

BY MR. PLOUFF:

Q. And I know this is probably not possible, but let's say that you were looking at a slide of tissue from a vagina, on the one hand one with no mesh in it and on the other hand the other tissue sample has mesh in it, would you expect -- or strike that.

Regardless of whether there's mesh in the vagina, you would expect the same type of inflammation in your Figure 2 as in a person who doesn't have mesh, is that correct?

A. Yeah, if you just see -- for example, if you take a sample of the vaginal wall in a patient, you can see chronic inflammation -- without mesh I'm talking about -- then you would see chronic inflammatory cells as well. There

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will be areas that have the same kind of finding. The only difference here is there is a foreign body, and in addition to the lymphocytes you get occasional foreign body giant cells.

Q. In a woman, contrasting the tissue samples of a woman without mesh and with mesh, do you see more chronic inflammatory cells in a woman with mesh?

A. Well, it depends on the woman as well. It depends on the immunological status of the woman and what other situations there are. But if you're talking about normal vagina, this amount of lymphocytes is similar, very similar to what you see in normal vagina sometimes.

Q. So if Dr. Iakovlev -- well, let me -- what kind of -- other than mesh explant surgeries, what kind of surgeries do you see with tissue samples from the vagina?

A. Oh --

MR. COMBS: Object to form.

A. I'm sorry.

Oh, many, many cases. Different repairs, different excisions of cyst, excisions of tumors, atypias, dysplasias. I get a lot of vaginal mucosa samples.

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BY MR. PLOUFF:

Q. Okay. So if we were to take a -- if we were to look at vaginal tissue samples from one of those kind of patients who doesn't have mesh but a pathologist will typically look at, and you compared the chronic inflammation in those cases with a mesh case, you would expect to see the same amount of chronic -- similar amount of chronic inflammation, is that correct?

A. Yes --

MR. COMBS: Object to form.

A. I'm sorry.

Yes, it depends on the patient, as I said. You know, there are patients that have more inflammation and there are others that have less. So it's really just syncretic.

But yes, you can have patients where there's a lot of inflammation and means nothing. Chronic inflammation I'm talking about.

BY MR. PLOUFF:

Q. And, Doctor, looking back at Dr. Iakovlev's report again, Page 14, Figure 5, do you see any plasma cells?

A. This magnification is too low to assess for plasma cells, so...

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Q. To you is a foreign body inflammation the same as chronic inflammation?

A. No. Chronic inflammation -- foreign body inflammation -- foreign body chronic inflammation is a type of chronic inflammation.

Q. Okay. And obviously you saw in some of these tissue samples for Mrs. Kaiser examples of foreign body type of inflammation, is that right?

A. Yes, that is correct.

Q. Did you see any other type of chronic inflammation other than foreign body?

A. No. The chronic inflammation that I saw was associated with, you know, the foreign body reaction.

Q. Okay. Going to Page 16 of Dr. Iakovlev's report, Figure 7, he's designated certain areas as dilated vessels. Do you agree that those are dilated?

A. No, I don't. I think they're absolutely normal.

Q. What does a dilated vessel look like?

A. Well, basically the lumen is larger than the rest of the normal vessels, so for that, actually, in order to assess dilatation of

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vessels, you would need to compare it to other areas of the tissue where, you know, if you wanted to illustrate dilatation of vessels in this, he -- in this situation he would have to compare it to the caliber of the vessels in an area that's not involved by the mesh.
Q. Are there -- in terms of the tissue slides that you looked at, are there areas that are not involved with the mesh?
A. In Ms. Kaiser you mean?
Q. Yes.
A. Yeah, Ms. Kaiser all the tissues pertain to the mesh.
Q. Okay. With regard to this Figure 7 where he's indicated dilated vessels, how would you describe the area that he points to?
A. I would just describe it as vessels.
Q. Okay. And what is the vessel that is -- is it the thin line of purple in that area of white?
A. No, it's the space.
Q. It is the space. So here's where I get confused, because, you know, in other cases where we looked at white areas it was mesh, and now here it looks like it's vessels. How do you

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distinguish the two?
A. Well, you have to go through a residency in pathology.
Q. Okay.
A. That's --
Q. I don't think that's going to happen, so -- but if you were going to -- but if I was the stupidest doctor in my class with an MD by my name and I asked you the question how do you know that what's designated here as dilated vessels is not really mesh, what would you explain to that student?
A. Okay. So basically you have to look for the lining of the vessel. The vessels are lined by endothelial cells. So if you noticed -- actually, it's not a very good magnification for that, but if you see the outline of those spaces, you will see like tiny black dots. Do you see that? Tiny, tiny, minute. So those are the nuclei of endothelial cells. That's what we use as a reference.
Q. I do see that. But it looks like those tiny, tiny black dots aren't in the area of the white, it's in the pink area.
A. Correct. Because the white area is

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where you have either blood or lymph, you know, the circulation. And the tiny dots are the nuclei of the cells that line the vessel, that surround that space.
Q. I got you.
A. Okay.
Q. Okay. Well, I should be able to pass your exam now, then.
MR. COMBS: I'm glad you asked that question, Tom, because that helps me.
BY MR. PLOUFF:
Q. Figure 8 on Page 17 of Dr. Iakovlev's report, the area that he's designated as nerve, do you agree?
A. Yes, it is a nerve.
Q. And is the nerve ingrown into the mesh?
A. Well, Dr. Iakovlev should know from his medical studies that a fiber this size would not ever -- would never regrow like this, in a mesh or anywhere.
Q. Well, is the nerve positioned within the scar tissue?
A. It is positioned within fibrosis, yes.
Q. And is it positioned within the mesh?

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A. It seems so, because there are mesh fibers in this picture, basically both sides of that nerve.
Q. All right. So is the nerve entrapped within the fibrosis?
A. Oh, I think the nerve was pre-existing, it was probably there, and it's just -- you know, there is -- the fibrosis grew, and he's somewhere in-between.
Q. With regard to --
A. When I say "he," it's an it.
Q. With regard to the nerve that's depicted in Figure 8 -- so is it the purple area that's the nerve, or what's the nerve?
A. The nerve is that pink ball with a lot of black dots inside.
Q. Okay. Do you see any evidence of degenerative changes within the nerve?
A. No. In order to assess that you have to do special stains.
Q. Like what?
A. Like with the ones that I mentioned before, like you have to do axonal stains, and you have to do neurofilament stains, and those are very specialized stains that were not done

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in this case.
Q. Dr. Iakovlev didn't do it and you didn't do it, is that right?
A. Yes. Correct.
Q. Do you think that it would aid -- for example, let's say you did those kind of studies and it showed that there was a degenerative nerve there, that would not be -- a degenerative nerve would not be related to mesh, is that right?
A. No, that's not what it means. It means that if you have a degenerated nerve, for example, and let's say you show that it's damaged, you don't know whether it was damaged during surgery, because obviously when -- you know, the nerves can get damaged during the actual implantation, not necessarily have anything to do with the mesh at all, or whether the damage was caused by processing, because that can happen as well when you -- the nerves are very delicate. When you handle them and you put them through so many reagents and use forceps, you can damage then.
So even if you do those things and you prove that there is some axonal damage, it may

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not give you any information at all as relates to pain in the patient.
Q. Now let's go to Page 19 of his report, Exhibit 1, Figure 10.
A. Yes.
Q. He identifies the neuroganglion, is that right?
A. Correct.
Q. And what is -- I see the arrow, but what is being pointed to that's the neuroganglion?
A. It's the whole structure that he -- that pink is like banana shape in this particular picture, but that -- if you see, it's similar to what we looked at before, except that there were like big -- two big purple balls inside that structure. You see that?
Q. Well, I actually got -- I actually digressed when you were talking to try to find the banana, and I think I have, but can you use your Sharpie to circle the banana representing the neuroganglion, please?
A. Yes, I could. (Witness complies).
Q. And then if you would repeat what you were saying about the other thing that's shown

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here.
A. Okay. So the way you identify ganglion is by identifying ganglion cells. So within this particular nerve you are going to see two structures that participate in that main nerve, and those are the ganglion cells.
MR. COMBS: Tom, just because obviously we're doing this by phone, if you go straight down from the arrow, Dr. Abadi is pointing to -- if you go about a quarter of an inch below the arrow there's a little circle, and then kind of slightly to the southwest of that there's another little circle. That's what Dr. Abadi was pointing to with her pen, but you can't see.
MR. PLOUFF: And has that been indicated by the Sharpie?
A. The Sharpie indicated the whole ganglion. But within that ganglion there are what we call ganglion cells, that's what our indication, that this is a ganglion.
BY MR. PLOUFF:
Q. Okay.
A. And those cells are like purple balls that you see within that shape.

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Q. And could you just take a line on those two purple balls and just at the end of the line write the word "ball"?
A. Okay. What I'll try to do is to circle those cells. Okay?
Q. Great.
A. So you will have a big circle for the entire structure, and then you will have these two small circles for the ganglion cells. Fair?
Q. Thank you.
Is there anatomic innervation shown here?
A. You mean autonomic innervation?
Q. I thought it was A-N-A-T-O-M-I-C.
A. No, it's not. It's autonomic, meaning we don't govern that, so it's autonomic, A-U-T-O-N-O-M-I-C. It's not anatomic. Everything is anatomic. So it's autonomic ganglion.
Q. Well, that will help me, and I think it helps the court reporter, because the transcript I was looking at for Dr. Iakovlev, it was written as anatomic.
So do you see an area of autonomic innervation here in Figure 10?

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A. Yes, the neuroganglion is part of the autonomic system.
Q. Okay. Does the phrase "scar plate" mean anything to you?
A. Well, I've seen it used by Dr. Iakovlev and some of the German researchers, but we don't use it in pathology.
Q. What does it mean?
A. I have no idea. I assume that it must be some form of encapsulation, but it's not currently -- it's not used as a terminology in pathology.
Q. Okay. Can -- so if I -- what's like the leading reference books in pathology?
A. Okay. So the leading book in pathology is Robbins.
Q. Okay. And do you think if I searched Robbins for scar plate I wouldn't find it? Is that right?
A. Yeah, I don't think so. You would have -- you would find scar, you would have fibrosis, but scar plate I doubt it, because we don't use it in our standard practice.
Q. Okay.
A. I've seen it -- I've also seen it

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always in quotes, so it's somewhat of a terminology that's used always represented with these quotes, so...
Q. Can the neuroganglion affect sensory innervation?
A. No, absolutely not.
Q. And why do you say that?
A. Because it's not -- that's not what they do. They are not pain fibers, they're not pain nerves, they're not sensory. They're motor, and they regulate the autonomic function of the tissues.
Q. Was this neuroganglion directly dissected away from the bladder wall?
A. Well, first of all, this is a vaginal mesh, so we assume that it's probably a vaginal ganglion. It has nothing to do with the bladder. And, you know, we don't know even if it's related to any particular function. There are so many functions that the autonomic ganglion perform, so just by looking at it you cannot possibly know its function.
Q. Do you -- in terms of any of the figures depicted in Dr. Iakovlev's report or in your report, are there any figures that you

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believe represent an area that's from the bladder wall?
A. No. Without the presence of urothelium, you cannot assess the presence of bladder wall in a specimen like this. And I wouldn't expect it because that would be terrible for a surgeon.
Q. Figure 10 is Page 19 in Dr. Iakovlev's report. The neuroganglion is identified there. Do you see any distortion in it?
A. I'm sorry, let me get to that part. What page did you say it was?
Q. Page 19 of Dr. Iakovlev's report.
A. Okay. 19. All right.
MR. COMBS: It's the one you drew.
A. Oh, it's the same one. All right. What did you say, I'm sorry, whether it's distorted?
BY MR. PLOUFF:
Q. Yes.
A. It doesn't look distorted to me.
Q. Okay. Are neuroganglions usually more rounded than what you see here?
A. Yes, but it depends on the angle of the cutting. You know, when we imbed tissues we

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can have what we call tangential sections, and so it gives you the image that it's deformed, but that's not the reality, it's an artifact of cutting and imbedding.
Q. Is this neuroganglion in Figure 10, is this involved in an area of fibrosis?
A. Yeah, there is fibrosis there, yes.
Q. Okay. Where is the closest mesh to this neuroganglion?
A. So if you see the picture is to, I would say, the right.
I'm always having trouble. How can I refer to him?
MR. COMBS: Tom, could you re-ask the question? Dr. Abadi is trying to figure out how to answer what you're asking.
MR. PLOUFF: Sure.
BY MR. PLOUFF:
Q. I'm still on Figure 10 at Page 19 in Dr. Iakovlev's report, Exhibit 1.
MR. COMBS: Yes.
BY MR. PLOUFF:
Q. And we see an area that's been identified as the neuroganglion, and my question is where is the closest mesh fiber to that

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neuroganglion?
MR. COMBS: Okay.
A. So it would -- I mean, I don't have a ruler with me, but it's --
MR. COMBS: She's pointing to the thing -- the white circle that is to the left.
MR. PLOUFF: Okay.
BY MR. PLOUFF:
Q. And, Doctor, if you could circle that white -- circle that area that's mesh and then label it as mesh, please.
A. Okay. (Witness complies).
Q. And when you've done that, let me know.
A. Yes, I'm done.
Q. Okay. Going to the next page of Dr. Iakovlev's report, Figure 11.
MR. PLOUFF: And let me get a -- from the court reporter, can you tell me where we're at in terms of time?
THE COURT REPORTER: You have 23 minutes left.
BY MR. PLOUFF:
Q. Page 20, Figure 11, do you see any nerve branches within the mesh?

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A. Well, I see nerve branches that are highlighted by the S100 staining, and I see some pores that are, you know, considered -- you know, that are mesh spaces, but I don't -- you know, it's very hard to see because it's a low magnification, and there's no H&E stain to see the morphology. There's nothing for comparison.
Q. I just -- you know, I see some brown areas, I see some yellow areas.
A. Okay.
Q. Do you know what the brown areas represent?
A. The brown areas represent the nerves.
Q. Okay. And then I know in Figure 1 the white circled areas have been yellowed by Dr. Iakovlev in the bottom picture, but are those all -- are those white areas again mesh areas?
A. Yes. Correct.
Q. Turning to Page 23 of his report, Figure 14.
A. Yes.
Q. Do you see nerve branches there?
A. Yes, I do.
Q. Do you see any nerve branches that are

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distorted?
A. I just see nerve branches. You cannot assess distortion again with this magnification and with this stain and with no comparison with any H&E stain.
Q. Okay. Now, Page 25 of Exhibit 1, Dr. Iakovlev's report, do you see an area of the mesh that he's labeled as a degradation layer?
A. Yes, I do.
Q. Do you agree with that description?
A. No.
Q. How would you describe what's being pointed to there?
A. Well, I see that, you know, outer surface layer, however you want to call it, but I don't know that that has been degraded.
Q. So you don't have an opinion one way or the other on whether it's degraded?
A. Well, I do not believe it's degraded just by the way it is. It's very smooth. If you were to talk about true degradation, what happens in the body, enzymatic or chemical degradation would not cause such a smooth layer at all. In fact, it would be very irregular.
Q. As a pathologist, does the phrase

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"degradation bark" have any meaning to you?
A. Well, bark does not exist, and degradation does exist. That is basically when the tissue disintegrates. So that word does exist, but bark does not.
Q. So again, if I looked at Robbins, you wouldn't expect me to be able to see the word bark, correct?
A. Correct. Yes. Unless they're talking about a tree.
Q. Or a dog?
A. Or what? Yes, or a dog.
Q. The last page of this report, Page 29, it appears that there's blue dots within the mesh, is that correct?
A. Yes, that is correct.
Q. What do the blue dots represent in your opinion?
A. I don't know. This is -- I know that there's a staining in this layer which, you know, does not correlate with polypropylene because polypropylene doesn't stain, so there must be some protein in there, but I do not know what those granules mean.
Q. Could they be splinters of the mesh?

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A. I don't know. I have no idea.
Q. Okay. So let's go to your four figures, Doctor, back to Exhibit 2.
A. Yes.
Q. And I would just ask you -- I'm going to have the same question probably for each one, but what is it that you plan on telling the jury about Figure 1?
A. Okay. So Figure 1, what I plan to tell the jury is that -- well, obviously there is mesh, there are mesh fibers, and that they are surrounded by fibrosis, which is what I expect to see once the mesh is implanted. And also mild chronic inflammation, which is what I'm pointing with the arrow, with the blue arrow.
Q. Okay. Figure 2, what do you plan on telling the jury?
A. Well, Figure 2 uses a higher magnification to illustrate that the chronic inflammatory infiltrate is composed of lymphocytes, which we spoke about, and also the chevron points out to a foreign body giant cell which is what you occasionally see in foreign body reactions, and obviously there is fibrous

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tissue around these fibers. And I also pointed out to those fragments of the fibers with the blue arrows as well.
Q. We haven't talked much about the foreign body giant cell, and I see your chevron there, but what are you pointing to?
A. You see that it's like a pink ball with a lot of little dots inside? It's like a little pink ball.
Q. Okay.
A. And so it has --
Q. Is that the only giant cell that you see depicted in Figure 2?
A. Yeah. There might be another one, but in this area, in this section, you don't see any more giant cells.
Q. Can you look at any of your four figures and tell me if you see a different giant cell located somewhere else?
A. Yes. For example, in Figure 3 you can see one in one of the superior spaces, there is a little one --
Q. Did you --
A. I'm sorry. Yes?
Q. Go ahead.

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A. There is one that looks like moon shaped.
Q. Okay. If you could circle those and identify them as foreign body cells, please.
A. Yes.
In that Figure Number 3?
Q. Yes.
A. (Witness complies). Okay.
Q. Okay. Now that we're on Figure 3, my same kind of a question, what do you plan on telling the jury about Figure 3?
A. Well, in Figure 3 I want to show the mesh, I want to show the inflammatory infiltrate that is actually just in the vicinity of the fibers. I'm showing also that the giant cells are, you know, just a few of them, also in the vicinity of the fibers. That the tissues that surround the mesh, except for a very thin rim of fibrosis, the rest is loose connective tissue. And the vessels that are present are totally unremarkable.
Q. And then on Figure 4 what do you plan on telling the jury?
A. Okay. Figure 4 is really the highest magnification, and that's just to illustrate how

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the giant cells look like, because obviously, you know, they are not pathologists, and so, you know, when we talk about giant cells, it's like what does this mean, so I want to just demonstrate how they look in tissues.
Q. Okay.
MR. PLOUFF: Let's go off the record for five minutes, and then I'll finish up the rest of my time.
MR. COMBS: Okay.
(Whereupon, a recess was taken from 12:32 p.m. to 12:45 p.m.)
(Whereupon, Abadi Exhibit Number 3, Five sheets of notes, was marked for identification.)
BY MR. PLOUFF:
Q. Doctor, handing you what's been marked as Exhibit 3, are those additional notes for the Barbara Kaiser case?
A. Yes, they are.
Q. You know, we were provided a neuropathologist report by a Dr. McLendon. Did you rely upon that report in any way for your opinions in the Kaiser case?
A. Yes, just for confirmation of my

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findings, because I have already -- I had already evaluated what I thought was the nerves in this case independently, so it just help as a confirmation.
Q. Okay. So, Doctor, so other than the fact that Dr. McLendon's report identifies the nerves that you also were able to identify, it adds nothing more to your opinion, is that right?
MR. COMBS: Object to form.
A. Correct. It's just a confirmation of my findings. And obviously he's a neuropathologist, so his report is very extensive into -- you know, he goes into the actual nerve evaluation.
BY MR. PLOUFF:
Q. Okay. But in terms of what you're relying upon his report for, in terms of that you accurately identified the nerve in the tissue samples, his report would be cumulative of what you already identified, is that correct?
A. Correct.
MR. COMBS: Object to form.
A. I'm sorry.
Yes, correct, I -- yes, I had already

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identified those nerves independently.
BY MR. PLOUFF:
Q. Okay. Did you review anything that led you to conclude one way or the other whether the Prolift mesh became folded and contracted while in Mrs. Kaiser's body?
A. Right. You know, as I said before when we were talking about this issue, a pathologist cannot evaluate folding or any position of tissue in vivo unless the surgeon identifies the location of the tissue. In other words --
Q. Okay.
A. -- it's not sufficient to just say "vaginal mesh." It has to actually to be appropriately oriented.
Q. Do you know what brand-new Prolift mesh looks like?
A. If I know how it looks like?
Q. Do you know what it looks like, yes.
A. The Prolift, yes, I've seen it. I've seen --
Q. Have you felt it?
A. If I have felt it?
Q. Yes.

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A. No, I have not felt it, except for the tissues that I got.
Q. No. I meant, you know, like let's say brand-new mesh out of the box, have you felt what that mesh feels like?
A. No, I have not, you know, palpated a kit of this, you know -- or the mesh.
Q. Can you tell me whether the mesh that was explanted from Mrs. Kaiser was soft or hard?
A. Well, it had to be -- everything had to be hard because it's imbedded into the fibroconnective tissue, so it feels hard.
Q. And is that true of all the explanted mesh that you've examined?
MR. COMBS: Object to form.
A. Yes, it's the -- it's true for every one.
BY MR. PLOUFF:
Q. Okay. Now, you referenced earlier the fact that Dr. Johnson's report references Dr. -- or Ms. Kaiser's complaint of pain during intercourse and pain while bending and stooping. Do you have any opinion as to what was the cause of Mrs. Kaiser's pain?
A. No, I don't, because I didn't examine

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Ms. Kaiser, I'm not a urogynecological pathologist -- I mean a clinician, a urogynecologist.
Q. If Mrs. Kaiser had pain upon physical examination when the tense bands that Dr. Johnson refers to was touched, do you have an opinion as to what caused Mrs. Kaiser's pain?
A. No, because as I said, I didn't examine her. I don't know what areas caused her pain. I wasn't present to a physical exam, so I have no idea. I wouldn't --
Q. Did you see any evidence of --
A. Sorry. I --
Q. Did you see any evidence of vaginal erosion in Mrs. Kaiser's tissues?
A. No. Actually the pieces that were sent to me and that were actually also evaluated by Dr. Iakovlev did not have vaginal mucosa.
Q. Okay. Did you see any evidence of vaginal atrophy?
A. Well, again, since it doesn't have epithelium, there's no way to assess atrophy.
Q. Would you have expected the mesh samples to have contained that?
A. Only if the surgeon submits that.

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Q. I see. Okay.
Is it true that the presence of nerves can cause pain?
A. Well, depends. You know, the presence of nerves can cause pain, can cause pressure, can cause touch sensitivity, can cause temperature, you know, perceptions. You know, nerves come -- you know, functional nerves have a lot of different functions basically.
Q. Sure.
You saw -- in regard to these tissue samples of Mrs. Kaiser, you saw nerves in-between mesh fibers, is that right?
A. Correct.
Q. Can those nerves have caused pain?
A. There's no way to know. We don't know what those nerves do. We don't know if they're pain fibers.
Q. Is there anything -- but are nerves a possible cause of pain?
A. Yeah, nerves can be a possible cause of pain, yes.
Q. Other than the nerves being a possible cause of pain in the tissue samples that you saw, can you identify anything else as a

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potential cause of pain?
A. Yes. If the surgeon in this case, Dr. Johnson, would have sent tissues from the epithelium, I could have, you know, identified if she had atrophy, an erosion, ulceration, and if there are other changes in the tissue such as an infection or acute inflammation, but I did not see any of that in Ms. Kaiser.
Q. Okay. All the opinions you've stated today, and they're stated in your report, are to a reasonable degree of medical certainty, is that correct?
A. Yes, that is correct.
Q. Is it possible to be 100 percent certain about your opinions?
A. I am 100 percent certain of my opinions, sir, yes, in this case.
Q. Okay. You have indicated today and in your report how Dr. Iakovlev is wrong in a number of ways, is that right?
A. Yes, that is correct.
Q. Is there anything that you think Dr. Iakovlev is right about in connection with Mrs. Kaiser's case?
A. Yes, there are things that he's right

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about, absolutely.
Q. What's he right about?
A. He's right about the inflammation. He's right about what constitutes inflammation in this case. He's right about that there's fibrosis present in this cases. So all that he's right about.
And that he highlights nerves, and those are truly nerves. What he's wrong about those nerves is what function those nerves, you know, fulfill.
MR. PLOUFF: Okay. Well, you know, I suppose I should think of more general questions to ask in my five minutes, but I'm actually finished. Thank you.
MR. COMBS: Sounds good. All right. Let's take a break for a second, and then I'm going to have some very brief redirect. It will be less than ten minutes, Tom.
MR. PLOUFF: Okay.
(Whereupon, a recess was taken from 12:54 p.m. to 1:03 p.m.)
CROSS EXAMINATION
BY MR. COMBS:
Q. Dr. Abadi, I'm going to ask you a few

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questions regarding the Kaiser case. First, I want to ask you a question about Exhibit 2. Mr. Plouff asked you some questions about Figure 3 on that. And did you stain -- strike that.
What is Figure 3?
MR. PLOUFF: I'm sorry, I missed -- are we talking about her Figure 3, or Iakovlev's?
MR. COMBS: We're on Exhibit 2, which is her four photomicrographs, and then Figure 3 of those.
MR. PLOUFF: Great.
BY MR. COMBS:
Q. So, Dr. Abadi, is this a slide that you made?
A. Yes, it is.
Q. And you then stained it with PAS?
A. Yes, I did. I stained --
Q. What is PAS?
A. PAS is a stain called periodic acid-Schiff stain, and it's a stain that is used for protein, and especially for glycoprotein.
Q. And is there pink staining on features in this photograph which are what Dr. Iakovlev calls degradation bark?

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A. Yes. I wanted to illustrate that that outer layer that Dr. Iakovlev refers to as "bark" is actually stains with periodic acid-Schiff, so that means that it has to contain protein, because otherwise it would not be stained.
Q. All right. Thank you.
Dr. Abadi, you were asked a number of questions regarding Dr. Iakovlev's conclusion that there is a layer of degradation. I want to ask you a follow-up question on that.
Did you review the slides and photomicrographs provided by Dr. Iakovlev?
A. Yes, I did.
Q. And did you review the tissue that is in approximation to the layer that Dr. Iakovlev claims is the degradation layer?
A. Yes.
Q. Did that tissue show any adverse histological findings?
A. No, there's no -- there are no -- there's no difference in the areas that have that outer layer from areas that do not have it. In other words, there is no associated inflammation other than chronic, there is no

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acute inflammation, there is no necrosis, there is no apoptosis, nothing that indicates anything different in relation to that layer from the rest of the specimen.
Q. And so the -- Ms. Kaiser's tissue response is the same in regard to sections of the mesh where Dr. Iakovlev claims there's a degradation layer and sections of the mesh where he cannot see a layer he claims is a degradation layer?
A. That is correct, there is no difference between areas that show that outer surface layer from areas that do not have it.
Q. Dr. Abadi, you were asked some questions about whether the mesh felt stiff to you. Was all of the mesh that was provided to you in this case or any other case mesh that had been preserved in formalin?
A. Yes. Ms. Kaiser's tissues were preserved in formalin. I received them in formalin.
Q. And what's the purpose of formalin?
A. Well, as I said, the purpose of the formalin is to basically fix the process of autolysis in the tissue, put a stop to it, so it

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basically just preserve the tissue.
Q. And does the process of fixation also harden the tissue?
A. Yes. It hardens the tissue because formalin basically is a chemical that causes stiffness in the tissues and also causes changes in coloration of the tissues, the tissues look darker, so yes, it modifies the correctness of the tissues.
Q. I want to ask you a question about Dr. Iakovlev's photomicrographs at BK2, BK3, BK4 where he has drawn his lines that he claims represent folding.
Now, is there a methodology that pathologists use to orient tissue to demonstrate where that tissue was in vivo?
A. Yes. We have a protocol for that. Basically, in order to orient the specimen, in order to know exactly where that specimen was positioned in vivo, the surgeon has to give us all the guidelines basically. So what the surgeon does in those instances where orientation is provided, he pins the tissue to a cardboard and then proceeds to mark the different areas as to where exactly that tissue

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was, anterior, posterior, medial, lateral, inferior, superior. If they don't use a cardboard, they can use other means of orientation such as sutures; you know, for example, one suture for superior, two for inferior, and so on, or staples.
So those are the -- in order for a pathologist to be absolutely certain and that this tissue is the way it is located in the human body is the assistance of the surgeon and all the guidelines.
Q. And you reviewed the pathology report and the specimen in this case?
A. Yes, I did.
Q. Had any of that methodology been followed for this specimen?
A. No, it wasn't followed. The surgeon did not orient the specimens.
Q. And if the surgeon has not oriented the specimen, how does that impact the pathologist's ability to make an after-the-fact orientation?
A. Well, once you receive a specimen that is not oriented, then basically you cannot do anything about that. And, in fact, the

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orientation of the specimen and the way the specimen looks changes through the processing, because not only you cut the specimen, but also you place it into a cassette, and it can be placed in, you know, upside down or whatever arbitrary position that the technologist is putting it into the cassette. So once you have an orientation, there is no way to put it back together.

Q. Dr. Abadi, I want to ask you a question now about Dr. Iakovlev's conclusions that the mesh impacted Ms. Kaiser's urinary symptoms.

Now, what would the methodology be that a pathologist would have to follow to make a determination about whether histological findings impacted clinical symptoms regarding the patient's urinary symptoms?

A. Okay. So urinary symptoms -- there are certain urinary symptoms that cannot be evaluated with pathology. What pathology can do for the urinary symptoms is if you have tissue from the bladder itself, if you have urothelium, transition epithelium, you can assess the degree of inflammation in that tissue, you can assess,

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you know, the status of the epithelium in the bladder. But, you know, in this case there was no submission of anything from the bladder, so there is no way to assess any urinary symptoms pertaining to these tissues.

Q. There are no histological findings in any of the slides or specimen that would allow a pathologist to draw that conclusion?

A. Correct, there is no way to correlate urinary symptoms with anything that we find in these tissues.

MR. COMBS: Dr. Abadi, thank you.

Tom, that is all the questions that I have.

Do you have redirect?

MR. PLOUFF: I do.

REDIRECT EXAMINATION

BY MR. PLOUFF:

Q. Doctor, there were two areas that I heard on the issue of methodology. One had to do with the methodology used to determine the orientation of the mesh to -- let's see, it had to do with the -- whether the mesh was folded in the tissue, is that right, or how you'd have to be able -- what kind of -- what the surgeon

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would have to do to tell you that?

A. Yeah. In order to establish the position of the mesh in the tissues, or even the shape of the mesh in the tissues, then the surgeon has to guide the pathologist in that regard. Because when they excise the mesh --

Q. Okay.

A. Excuse me, I was trying to explain.

When you excise -- when the surgeons excise the mesh they're pulling the mesh out. So the way it comes folded, if it comes folded, it has nothing to do with the way it was positioned in vivo, because obviously they are pulling, they're tugging, they are cutting with scissors, they're cutting with cautery. So the mesh is being subjected to a lot of manipulation.

So if the surgeon is truly interested in telling the pathologist, or it's important in that sense to give that information to the pathologist so the pathologist can put it together, then the specimen has to come down in a different way. It cannot come in three regular pieces, and then you try to put Humpty Dumpty together, it doesn't work that way.

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The surgeon needs to give orientation, he needs to position the mesh exactly how it was in a cardboard designated correctly; otherwise, everything that you do with that tissue, you know, whatever orientation you give to it is speculative, because you really don't know what is right, what is left, how is it curved, is it anterior, is it posterior. You understand what I mean? It's all speculation.

Q. So you've now explained the methodology that a pathologist would have to follow to come to some conclusion about the position of the mesh in the tissue or the shape of the mesh, correct?

A. Correct, yes.

Q. All right. And you've also explained a methodology for how to determine if the urinary symptoms were related to the mesh, is that correct?

A. Right. In a situation like this, you can only tell what, you know, what you see in that mesh, but you cannot correlate it with urinary symptoms.

Q. Okay. And did this methodology that you're referring to, I mean, is this something

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that you learned back when you were doing your residency in pathology?
A. Yeah, that's correct. You learn that when you learn how to process specimens --
Q. So obviously the --
A. -- so all pathologists follow that. I'm sorry. Yes?
Q. So obviously at the time that you issued this report in March, 2016 in Mrs. Kaiser's case, you knew about the methodology, correct?
A. Oh, yes, I do it in my practice all the time.
Q. And yet there's nothing in your written report about Mrs. Kaiser that criticizes on the basis you just had, the methodology employed by Dr. Iakovlev regarding the urinary symptoms or the position of the mesh in the tissue, correct?
MR. COMBS: Object to form.
A. Well, first of all, regarding the urinary symptoms, I have a portion in my report that talks about that. I said "Urinary symptoms. Ms. Kaiser complains of bladder spasm and urinary frequency, which Dr. Iakovlev claims

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is a result of damaged neuroganglion. There is no reliable evidence that the neuroganglion present in Ms. Kaiser vaginal specimen has any relationship with her urinary symptoms. During mesh excision, Ms. Kaiser's urinary bladder was found to be normal." So that is a paragraph in my report that pertains to urinary symptoms.
Regarding the folding of the mesh, I said "The mesh photographs only show mesh fibers within fibrous tissues. These photographs have been purposely and selectively modified in an attempt to show the most likely orientation of mesh layers. Neither one of these pictures demonstrate how the mesh was actually positioned in the patient." So I did talk about it in my report.
Q. Okay. Well, if you would, read for me in your report where you explain the methodology that would need to be followed in order to determine whether urinary symptoms were related to the mesh. Read to me that part, please.
A. Well, first of all, as I said, this methodology has nothing to do with urinary symptoms. This methodology has to do with the position of the mesh in vivo, which I was not

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going to evaluate, because I, as I said, I didn't have that information. Why should I include it in my report?
MR. PLOUFF: Move to strike as non-responsive.
BY MR. PLOUFF:
Q. Doctor, this simply involves you reading from your report, and if you say there's nothing in your report that says it, I'll accept that as an answer.
But my question is, read from your report anything that you have to say about what the proper methodology is that needs to be followed in order to determine whether urinary symptoms are related to mesh.
A. I did not include the protocol that we follow in pathology to properly orient the specimen, no, I did not include that.
MR. COMBS: Dr. Abadi, he's asking you the urinary symptoms, not the --
A. Oh, the urinary symptoms have nothing to do with the orientation, with the methodology of the orientation.
MR. COMBS: Tom, you guys are speaking past each other, so maybe you can ask the

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question again.
A. Oh, sorry. I will let you speak first.
BY MR. PLOUFF:
Q. Okay. Well, there were -- in the questions that Ethicon's counsel just asked you, you explained methodology in two areas, as I understood it. One was the methodology that would have to be followed to determine if urinary symptoms were related to the mesh, is that correct?
MR. COMBS: Object to form.
A. I think there were -- I think we're confused about two different issues here. One is the correlation of urinary symptoms with the findings in this tissue. That's one thing.
The other one, which is separate, is how -- the protocol that is used in order to orient the specimen and to know how that specimen -- if it was folded, or how it was positioned in vivo.
So those are two different things. I'm not overlapping them. I'm basically answering two different questions.
BY MR. PLOUFF:

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Q. And I'm trying to ask two different questions.
A. Okay. So --
Q. And the first one -- and I want to do this -- do it the two ways that I heard Ethicon counsel do it. One area is urinary symptoms that I want to go into now, and the other area has to do with the orientation of the mesh.
So as to the urinary, you went through with counsel your explanation of the methodology that would have to be followed in order to determine if urinary symptoms were related to the mesh. Is that accurate or not?
MR. COMBS: Object to form.
A. Okay. So in terms of urinary symptoms, it's not that there's a methodology about urinary symptoms. What the urinary symptoms -- in order to assess urinary symptoms, what it entails, you need to have bladder in a particular case such as this, which we don't have. So it's not that there's no methodology, it's just that we don't have that tissue here.
BY MR. PLOUFF:
Q. All right.
A. So obviously cannot be assessed.

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That's what I meant by urinary symptoms.
MR. PLOUFF: I'm going to need to have the reporter go back during Ethicon counsel's questioning and search for the word methodology, and I want the -- we're going to start from the end, the last time that methodology was used in a question before I started my questioning. If you could read that to me, please.
MR. COMBS: Okay. And, Tom, also you're out of time. I mean, if you want to follow up --
MR. PLOUFF: I'm not out of time when you conduct an examination and I need follow-up.
MR. COMBS: Yes, you are out of time. Your time is cumulative of both your direct and your redirect, so you are out of time.
Now, if you want to follow up on this, I'm going to let you, but I'm just telling you, you've used your two hours.
MR. PLOUFF: All right. Well, I'm going to keep asking questions as follow-up, and if you want to terminate the deposition, then we can get Judge Eifert on the phone again.
MR. COMBS: Okay. Well, if you're going to -- why don't you give me an estimate of

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how long you think you're going to take, because if you're going to take --
MR. PLOUFF: Well, I don't -- I think I have -- you know, I mean, I think I've got five minutes, ten minutes maybe. I don't know.
MR. COMBS: Well, okay. Ms. Court Reporter --
MR. PLOUFF: I mean, probably a comparable amount of time that you -- whatever time you took, it's probably going to be comparable to that.
MR. COMBS: How long has Mr. Plouff taken?
MR. PLOUFF: Well, we're not going to include all this colloquy, and your objection time and all that, so...
(Off the record discussion.)
MR. COMBS: Ms. Court Reporter, I just want to place on the record that we have had an extensive colloquy off the record, and in that colloquy I've pointed out to Mr. Plouff that he is past his two hours for this deposition. I'm going to permit him some additional time. Right now he's at two hours and four minutes. I told him I'd give him five more minutes.

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And Mr. Plouff has asked that you -- that the court reporter, you, search for a methodology question, and so, you know, please do that search, and then after you have done that search, then we'll go back on the record.
But it is my position that at the end of five minutes, I'm going to be done with the questioning in this case.
MR. PLOUFF: And my response is that I identified the three areas that you went into in your examination that I'm looking to respond to, and that I think it can be a very short examination if the witness is directly responsive.
MR. COMBS: So if you could do that search now, please.
(Whereupon, the reporter read back the requested question.)
MR. PLOUFF: We're back on the record then.
BY MR. PLOUFF:
Q. Doctor, you were asked a question about what the methodology was for a pathologist to determine if histological findings in past clinical symptoms regarding a patient's urinary

symptoms, right?
A. That is correct.
Q. And you explained that methodology, correct?
A. I did.
Q. And that methodology -- can you read anything from your report on Mrs. Kaiser's case where you explained that methodology?
A. No.
Q. All right. Can you read anything from your report -- you also were asked questions regarding the methodology used by a pathologist to orient tissue to mesh, correct?
A. Yes, to orient any specimen, not just mesh.
Q. Can you point to anywhere -- can you read from your report where you explain that methodology that's used by a pathologist to orient tissue to mesh?
A. No, I did not explain the methodology because I didn't -- you know, I'm a pathologist. I don't need to explain all the methodology for orientation.
Q. All right. Now, you said that in looking at Figure 20 of Dr. Iakovlev's report,

and that's Page 29, do you see areas of inflammation near the area that's labeled "Detached degradation bark"?
A. Yes, I don't see any inflammation. There's no inflammation.
Q. So again, the pictures in the -- the Figure 20 pictures on Page 29, the very top picture, you see no sign of inflammation in that picture, is that correct?
A. Correct.
Q. You see no -- you see signs of fibrosis?
A. Fibrosis I do see, but I do not see any inflammation.
Q. All right. With regard to Figure 3 in your report --
A. Yes.
Q. -- Exhibit 2, you reference the fact that, you know, what Dr. Iakovlev had identified as bark is really protein, and you can see the protein in this Figure 3, is that right?
MR. COMBS: Object to form.
A. Well, first of all, what I said is that this outer layer stains with PAS, the periodic acid-Schiff with glycoprotein stain, so

it does stain with that, which means that it has to have some protein in it. I don't know what the layer is entirely composed of, but certainly it stains with PAS.
Q. And if you could just circle an area that's an example of -- that you believe represents protein.
A. Yes. Well, actually, I don't even need to circle it, it's actually highlighted by a blue arrow in my figure. Do you see that?
Q. Is that like the pink band that the arrow is pointing to?
A. Correct. Yes.
Q. Okay. And if you could label that -- underneath the arrow, if you could label that as "protein," please?
A. (Witness complies).
MR. PLOUFF: And that's all the questions I've got.
MR. COMBS: All right. Thank you. We'll read and sign.
MR. PLOUFF: And I would like an E-Tran with a PDF of exhibits, please.
(Whereupon, the deposition was concluded at 1:32 p.m.)

STATE OF NEW YORK)
COUNTY OF ERIE)

I, MAUREEN O'CONNOR POLLARD, RMR, CLR, and Notary Public in and for the State of New York, do certify that on the 31st day of March, 2016, at 10:27 o'clock, the person above-named was duly sworn to testify to the truth of their knowledge, and examined, and such examination reduced to typewriting under my direction, and is a true record of the testimony given by the witness. I further certify that I am neither attorney, related or employed by any of the parties to this action, and that I am not a relative or employee of any attorney employed by the parties hereto, or financially interested in the action.

In witness whereof, I have hereunto set my hand this 3rd day of April, 2016.

_____
MAUREEN O. POLLARD, Notary Public
My Commission Expires: 3/14/19
Realtime Systems Administrator